MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

05967

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH

County: Charles

City or town: La Plata Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6-12-47 to 7-6-47

Hospital, Institution, or street address where death occurred: Physo-Mem. Hosp La Plata, Md.

How long in hospital or institution? 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Port Tobacco, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Linda Marie Greer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	S.

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 6-12-47

8. AGE: Years | Months | Days: 24 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Welcome, Chas, Md.
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER
12. Name: LeRoy Greer
13. Birthplace: Welcome, Md.

MOTHER
14. Maiden name: Mamie Heyman
15. Birthplace: Charles Co, Md

16. Informant: Mrs. J. Leroy Greer
Address: Port Tobacco, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-7-47 (month) (day) (year)

Cemetery or crematory: St. Ignatius

Location: Hilltop, Md

18. Funeral director: Hewett & Ryon

Address: Waldorf, Md

19. 7-7 19 47 (Date rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-6 1947, at 5P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-12 1947, to 7-6 1947 and that I last saw h[illegible] alive on 7-6 1947

Immediate cause of death	DURATION
Atelectasis	7-6-47
Due to: Prematurity (5 mo. 24 days)	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: La Plata Md Date signed 7-7-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

05968

CERTIFICATE OF DEATH

Reg. Dist. No. 101

1. PLACE OF DEATH:
County: Charles
City or town: Bouncaster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles.
City or town: Bouncaster
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mary Francis Hammack

3. (b) Social Security Number:

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Homer Hammack
6.(c) If alive, give age ... years
7. Birth date at deceased (mo., day, yr.): July 27 1857
8. AGE: Years: 90 Months: 6 Days: 1 If less than one day: ... hrs. ... min.
9. Birthplace: Bouncaster Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Unknown
13. Birthplace: Record destroyed
MOTHER 14. Maiden name: Betty Cafes
15. Birthplace: Charles C. Md.
16. Informant: Bryan Hammack
Address: Bouncaster Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 31 1947 (month) (day) (year)
Cemetery or crematory: Chicamuxen Methodist
Location: Chicamuxen Md
18. Funeral director: Hunt & Ryon.
Address: Waldorf Md.
19. July 29 1947 (Date rec'd by registrar) Mary Smythe Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 19... at 12 noon
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 06, to July 28 19 47
and that I last saw h... alive on July 28 19 47
Immediate cause of death: Chr. Cardio renal disease — DURATION
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George C. Bicknell MD M. D. or other
Address: Marlboy Md Date signed July 29 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

05969

CERTIFICATE OF DEATH

Reg. Diat. No. 100

1. PLACE OF DEATH:
County: Charles
City or town: Rock Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Rock Point
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: James Mortimer Hill

3.(b) Social Security Number

4. Sex: M
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Alberta Hill
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): May 2, 1882
8. AGE: Years: 65 Months: 2 Days: 19 If less than one day: ... hrs. ... min.
9. Birthplace: St. Mary's Co. Md. (Town, county and state)
10. Usual occupation: Merchant
11. Industry or business:
FATHER 12. Name: William Giles Hill
13. Birthplace: St. Mary's Co. Md.
MOTHER 14. Maiden name: Julia Josephine Hagel
15. Birthplace: St. Mary's Co. Md.
16. Informant: Earl Hill
Address: Rock Point, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/24/47 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland, Md.
18. Funeral director: Hunter & Ryan
Address: Waldorf, Md.
19. 7-24 1947 (Date rec'd by registrar) Julia H Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-21 1947 at 5 00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-2 1947, to 7-21 1947
and that I last saw him alive on 7-21 1947

Immediate cause of death	DURATION
Coronary Occlusion	7-21-47
Due to: Arterio-Sclerotic Heart Disease	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ... Injured at work?

23. SIGNATURE: E Kelleher M. D.
M. D. or other
Address: LaPlata Md Date signed 7-23-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 140 b

05970

CERTIFICATE OF DEATH

Reg. Dist. No. 104

1. PLACE OF DEATH:
County: Charles
City or town: La Plata, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Physicians Memorial
How long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Chas.
City or town La Plata rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Indian Head Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Kathleen Rebecca Mack

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col	Married

6.(b) Name of husband or wife: LeRoy Mack
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 23, 1923

8. AGE: Years	Months	Days	If less than one day
23	6	23	hrs: min.

9. Birthplace: La Plata, Md. (town, county, and state)
10. Usual occupation: Housework
11. Industry or business
FATHER 12. Name: Arthur James Scroggins
13. Birthplace: Chas Co. Md
MOTHER 14. Maiden name: agnes Johnson
15. Birthplace: Chas. Co. Md.
16. Informant: Margaret Scroggins
Address: La Plata, Md.
17. (Burial, cremation, or removal. Which?) Burial Date thereof 7/19/47 (month) (day) (year)
Cemetery or crematory: Sacred Heart
Location: La Plata, Md.
18. Funeral director: Hunter & Ryon
Address: Waldorf, Md.
19. 7/18 19 47 (Date rec'd by registrar) Julia H Casey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 July 47 19 EST at 3:07 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 June 19 47 to 16 July 19 47 and that I last saw her alive on 16 July 19 47

Immediate cause of death	DURATION
Cardiac — respiratory failure	
Due to Septicemia	23 June 47 to 23 July 47
Due to Infected abortion. At a later date developed a generalized peritonitis which produced septicemia. (10/1/47 as)	31 May 47
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Gynecological Autopsy
Date of op. 25 June 47
Autopsy results: not done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) No
Means of injury Injured at work?

23. SIGNATURE: J O Woodward, M.D. (M. D. or other)
Address: Box 214 La Plata Md. Date signed: 18 July 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 134a

CERTIFICATE OF DEATH

05971

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH
County Charles
City or town La Plata Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Physicians Memorial Hospital
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Charles
City or town Waldorf Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William M. Raley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Hattie
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Apr 12 - 1886

8. AGE: Years	Months	Days	If less than one day
61	3	10	..... hrs. ..... min.

9. Birthplace Waldorf MD
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name William A. Raley
13. Birthplace Waldorf Md

MOTHER
14. Maiden name Mary Williams
15. Birthplace Waldorf Md

16. Informant Hattie Raley wife
Address Waldorf Md

17. Buried Date thereof 7-28-47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St Paul Priney
Location Waldorf Md
18. Funeral director Hamett & Ryon
Address Waldorf Md

19. 7-25-47 Julia H. Posey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1947 at 3:50 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23 1947 to July 23 1947 and that I last saw h... alive on July 23 1947

Immediate cause of death	DURATION
cerebral & coronary thrombosis	
Due to generalized arteriosclerosis	5-10 yrs
Due to	
Other conditions Rt. pyonephrosis Rt. staphylococcus	

(Include pregnancy within 3 months of death).

Major findings of operations
Date of op.
Autopsy results See above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Alfred L. Lapen, M.D.
M. D. or other
Address Ogle Co. Md Date signed July 23, 1947

BIRTH AND DEATH 160a 05972

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF ~~STILLBIRTH~~

Reg. Dist. No. 100

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Charles

City or town La Plata

(If outside city or town limits, write RURAL and give nearest town)

Street address, hospital, or institution: Physicians' Memorial Hospital

Length of mother's stay in County

(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland

County Charles

City or town Waldorf

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If RURAL give LOCATION)

3. Name of child Vernon

4. Date of birth July 24 1947 Hour 12 [illegible] A.M.

5. Sex male | 6. Twin or triplet —

7. No. of weeks pregnancy 24 12:15 P.M.

FATHER OF CHILD

8. Full name Harold Woodrow Vernon

9. Color W 10. Age at time of this birth 30 yrs.

11. Usual occupation Farmer

MOTHER OF CHILD

12. Full maiden name Vera Salmons

13. Color W 14. Age at time of this birth 40 yrs.

15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 7

(b) How many other children were born alive but are now dead? 1 (c) How many other children were *born* dead? 0

17. Did child die before labor? No During labor? No

18. Pregnancy, complications of None

19. Labor: (a) Complications of None

(b) Induced? No

20. (a) Was there an operation for delivery? No (Yes or No)

(b) State all operations, if any None

(c) Did child die before operation? No

During operation? No

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Intramural implantation of placenta

(b) Maternal causes Overwork

22. I certify to the birth of this child who was born ~~dead~~ alive on the date and hour above stated.

Signature James E. MacKavanagh M.D.

(Specify if M. D., midwife, or other)

Address La Plata, Md.

23. (a) Burial (Burial, cremation or removal) (b) Date thereof 7-24-47 (month) (day) (year)

(c) Cemetery or crematory Garden Lawn

24. (a) Funeral director Harold Vernon

(b) Address Waldorf Md.

25. (a) 7-27-47 (Date rec'd by registrar) (b) Julia H. Posey (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.

Health Officer, per

* See Instruction C on stub.

V. S. A10

Child lived 15 minutes

BIRTH & DEATH 05973

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF ~~STILLBIRTH~~ 1600

Reg. Dist. No. 10-0

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:
   County: Charles
   City or town: La Plata
   (If outside city or town limits, write RURAL and give nearest town)
   Street address, hospital, or institution: Physicians Memorial Hospital
   Length of mother's stay in County:
   (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:
   State: Md.
   County: Charles
   City or town: Potomac Heights, Indian Head
   (If outside city or town limits, write RURAL and give nearest town)
   Street No.: 138 - Circle Avenue
   (If RURAL give LOCATION)

3. Name of child: Fred Gerald Wrigley, III
4. Date of birth: July 17, 1947 Hour: 3:18 P.M. (EST)
5. Sex: Male | 6. Twin or triplet: —
7. No. of weeks pregnancy: 21

FATHER OF CHILD

8. Full name: Fred Gerald Wrigley, Jr.
9. Color: White 10. Age at time of this birth: 29 yrs.
11. Usual occupation: Payroll Supervisor

MOTHER OF CHILD

12. Full maiden name: Doris Lillian Worth
13. Color: White 14. Age at time of this birth: 28 yrs.
15. Usual occupation: Housf.

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 1
(b) How many other children were born alive but are now dead? 0 (c) How many other children were *born* dead? 0

17. Did child die before labor? No During labor? No
18. Pregnancy, complications of: Threatened miscarriage past 3 months
19. Labor: (a) Complications of: None
(b) Induced? No
20. (a) Was there an operation for delivery? No (Yes or No)
(b) State all operations, if any: None
(c) Did child die before operation? No
During operation? No

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
(a) Fetal causes: Placental infarcto
(b) Maternal causes: Endometritis

22. I certify to the birth of this child who was born ~~dead*~~ alive on the date and hour above stated.
Signature: James L. MacKavanagh M.D.
(Specify if M. D., midwife, or other)
Address: La Plata, Md.

23. (a) Burial (Burial, cremation or removal) (b) Date thereof 7-17-47 (month) (day) (year)
(c) Cemetery or crematory: Fairlawn
24. (a) Funeral director: F. G. Wrigley II
(b) Address: 138 Circle Ave. Pot. Heights, Md.

25. (a) 7-17-47 (Date rec'd by registrar) (b) Julia H. Posey (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.
Health Officer, per

* See Instruction C on stub.

V. S. A10

Child lived 2 hrs - 12 min